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AUTHOR	Wagenfeld, Morton O.; Murray, J. Dennis; Mohatt, Dennis F.; DeBruyn, Jeanne C.
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ABSTRACT

The rural community mental health center tends to serve a large geographic area, have decentralized service delivery, require its professionals to function as generalists, and coordinate closely with other agencies. The last decade has seen an increasing strain placed on this pattern. As block grant and fee-for-service shifts resulting from the Omnibus Budget Reconciliation Act of 1981 took hold, the rural community mental health center was forced to step away from its role as a multiservice agency accessible for general community utilization and into a narrower role of service provider to the seriously impaired or those able to pay. In already underserved rural areas, this has generated immense challenges for mental health professionals to provide services to persons other than those with chronic mental illness. Successful alternatives and innovations are discussed, including linkages with primary care physicians and training indigenous residents to provide basic mental health services under professional supervision. Innovative rural prevention programs link parents and young children to child development professionals, build self-esteem in at-risk youth, respond to families affected by the farm crisis, and detect and prevent school adjustment problems. A literature review found few rural programs addressing the issues of substance abuse; services to women, children, the elderly, those with severe mental illness or developmental disabilities, and the homeless; or crisis intervention. (Contains 59 references.) (TD)

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Mental Health Service Delivery in Rural Areas: Organizational and Clinical Issues

Morton O. Wagenfeld, J. Dennis Murray, Dennis F. Mohatt, and Jeanne C. DeBruyn

The discussions of the demography, values and culture, and the prevalence of mental disorder and substance use and abuse in rural areas have provided a context for understanding some of the problems of mental health services delivery. This chapter addresses the organization and clinical issues related to the delivery of effective mental health services to rural populations.

As noted elsewhere, the myths of rural homogeneity and rural tranquility are exactly that—myths without substantive validity. Mental health professionals working in rural areas are faced with challenges associated with these myths, in addition to the challenges of underfunding, understaffing, and cultural barriers to help seeking and caregiving. The inappropriateness of the urban model of service delivery has prompted the development of models suited to the rural context. This chapter reviews some of these models developed in the past decade.

ORGANIZATIONAL CHARACTERISTICS

Organizations are reflective of the environments within which they operate. The environment for mental health care in rural areas discussed previously (Flax et al. 1979) was considerably different from today's. In 1979, the Community Mental Health Centers Act of 1963 was the vehicle through which the majority of rural mental health efforts at the community level were organized. A direct relationship between the local program and the Federal source (i.e., National Institute of Mental Health (NIMH)) was the norm (Hargrove and Melton 1987).

The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) initiated a major shift in the funding environment relating to mental health services. OBRA 19981 authorized the Alcohol, Drug Abuse and Mental Health Services Block Grant program, which shifted the direct relationship away from the Federal source of funding and to State mental health authorities. This restructuring appears to have initiated a shift in programmatic focus

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toward an emphasis on services to persons with serious mental illness. The initial shift to block grant funding also resulted in a 25 percent reduction in Federal support for mental health services (Andrulis and Mazade 1983).

Hargrove and Melton (1987) noted that the block grant shift, with its accompanying reduction in mental health funding, placed an increased emphasis on fee-generating services. Rural public mental health care providers, who are often the sole source of such care in rural areas, receive a majority of their funding from Medicaid fee-for-service programming (Mohatt 1992).

In summary, the major organization shifts in rural mental health service delivery in the past decade or so were significantly linked to the shifts in the funding environment. Block grant legislation removed the major link between Federal mental health authority (NIMH/Alcohol, Drug Abuse and Mental Health Administration (ADAMHA)) and local programs, and heralded a departure from the priorities of the 1963 Community Mental Health Center Act.

COMMUNITY MENTAL HEALTH CENTERS

The 1963 Community Mental Health Centers Act, strengthened by its 1975 amendments, required mental health programs to provide five core elements of service: outpatient, inpatient, consultation and education, partial hospitalization, and emergency/crisis intervention. The act also required linkages to the community and community agencies to enhance the community mental health center's ability to meet the community's needs in a responsive manner. Woy and colleagues (1981) noted that the rural community mental health center was most likely to adhere to the intent of this model.

As stated earlier, in the public mental health models, the community mental health center is usually the major source of mental health care in rural areas. Numerous articles have documented the shortage of mental health professions in rural American. This shortage of professionals has often resulted in a lack of private-sector mental health alternatives for rural residents, as well as being a major staff recruitment obstacle to the public provider.

The rural community mental health center tends to serve a large geographic area, have decentralized service delivery, require its

professionals to function as generalists, and coordinate closely with other agencies (Brown and Leaf 1985; Flax et al. 1979; Hargrove and Melton 1987; Murray and Keller 1991). The last decade has seen an increasing strain placed on this pattern. As the block grant and fee-for-service shifts took hold, the rural community mental health center was forced to step away from its role as a multiservice agency accessible for general community utilization and into a narrower role of provider of services to the seriously impaired (defined by the State, rather than the community) or those able to pay.

Hargrove and Melton (1987) noted the potential for conflict as a result of the need for community mental health centers to charge fees, while most other public sector, tax-supported agencies (such as social welfare and public health agencies) do not charge fees. Additionally, community mental health centers began to focus almost exclusively on providing services reimbursable by third-party payers. The potential appears to have proven the rule, rather than the exception. For example, many have noted that the inability of the community mental health center system to proactively respond to the "farm crisis" was the result of this shift of focus and dependence upon reimbursable fee-for-service care delivery (Bergland 1988; Cecil 1988). In short, community mental health centers have become less able to respond to evolving community mental health care demands because funding mechanisms have shifted to defined problem and procedure fee-for-service reimbursement patterns.

The move away from the intent of the Community Mental Health Center Act has resulted in most community mental health centers focusing their efforts on programs mandated by the State mental health authorities and away from those defined by their local communities and catchment areas. The focus on services to the most seriously impaired, coupled with the lack of private caregiving alternatives, has created a situation in which many rural persons with less than chronic mental illness go underserved.

Many States have abandoned the model of free-standing community mental health centers and have moved toward systems of privatization and managed care. This is reflected in a 1992 proposal before the National Council of Community Mental Health Centers to remove "Community Mental Health Centers" from its title, replacing it with "Mental Healthcare Providers" or "Behavioral Healthcare Providers." Additionally, several State mental health authorities (Vermont, Ohio, Minnesota, Massachusetts, and Utah) have moved toward systems of managed care, capitated, or per-capita funding. The implications of these moves for rural areas have yet to be documented. It would seem,

however, that all of these systems would require certain economies of scale that would not fit into rural population patterns.

INPATIENT SERVICES

In 1988 more than 95 percent of the most urbanized counties in major or medium-sized metropolitan areas had psychiatric inpatient services, in contrast to only 13 percent of rural counties (U.S. Congress 1988). Wagenfeld and colleagues (1988) noted that nonmetropolitan communities, which encompass 28 percent of the Nation's population, contain only 0.1 percent of the psychiatric beds. Rural populations have significantly less access to inpatient resources within their communities, and most rural residents must receive inpatient care outside of their community.

Since the inception of the 1963 Community Mental Health Center Act, which accelerated the process of deinstitutionalization, the utilization of State psychiatric facilities has declined dramatically. In Michigan, for example, the number of patients in State psychiatric hospitals has gone from 19,059 in 1960 to 2,807 in 1991 (Michigan Department of Mental Health 1991). Similar patterns exist in most other States. Although in the last decade there has been rapid growth in the number of private psychiatric beds in the United States (Redick et al. 1989), this has not been true for rural America. In 1988, the U.S. Department of Health and Human Services estimated that 61 percent of the total rural population lived in designated psychiatric shortage areas. Additionally, only 17 percent of rural general hospitals provided psychiatric emergency services, compared to 32 percent of urban hospitals (U.S. Congress 1988). This trend may be changing as rural hospitals begin to develop psychiatric beds.

Anecdotal data (Elkin, personal communication 1990; Ozarin, personal communication 1989) point to the entry of private psychiatric hospitals (e.g., Charter Hospitals, PIA) into rural areas, either as free-standing facilities or as leased beds in non-Federal general hospitals. Stuve and colleagues (1989) noted that the number of private psychiatric beds in Nebraska's nonmetropolitan areas increased form 9 to 172 from 1981 to 1988.

Because the trend is toward for-profit psychiatric bed development, however, the growth in this area may take the payer mix away from publicly funded hospitals and outpatient clinics. In the current health care financing system, where many individuals can exhaust their lifetime

mental health insurance benefit quickly in a private inpatient setting, these individuals then turn to the public system without benefits or ability to pay for services (Mohatt 1992). Considerably more investigation in this area is warranted.

Studies have demonstrated several viable alternatives to provide rural residents with enhanced access to inpatient care. Miles (1980) discussed a project linking four teaching hospitals with specific underserved communities in British Columbia. The project combined psychiatric outreach for training and consultation with local physicians and allied health care professionals with 24-hour access to telephone consultation. As a result, the local general hospital was able to improve service to individuals experiencing psychiatric crises.

The Michigan legislature passed a law in 1990 that allows acute care beds in rural general hospitals to be used for 72-hour psychiatric stabilization. At this time several rural community mental health centers are negotiating cooperative agreements with general hospitals to facilitate such utilization. Paramount concerns revolve around hospital staffs' wariness of the patient with mental illness. Such wariness could most likely be reduced through training and joint staffing.

SUBSTANCE ABUSE SERVICES

Public policy concerning substance abuse services in rural settings has evolved significantly during the past three decades. In the early 1960s, drug abuse was seen to be an urban problem, and public policy focused on the urban needs. Later, in the early 1980s, drug abuse was viewed as a problem that spread, like a contagious disease, outward from the urban areas into rural American (Seidler 1989). During this period, policy-makers discussed alcohol and drug abuse primarily as separate issues. But a major change evolved in the next decade: alcohol and drug abuse were considered as part of the broader issues of chemical dependency, addiction, and substance abuse.

The research relating to the epidemiology of drug and alcohol use and abuse in rural America has been covered elsewhere (Wagenfeld et al. 1994). Little is available, however, concerning effective rural drug and alcohol use and abuse service delivery. Presenters at several annual conferences of the National Association for Rural Mental Health have discussed programs that effectively address rural substance abuse

services delivery. An extensive review of the literature for this project yielded few program descriptions or evaluations.[1]

Many rural substance abuse programs seem to be based on urban models (Kutner 1982). It is important to begin addressing rural environments and values in the design and implementation of programs. Some programs have made the effort to match the delivery system to the rural environment. Beltrane (1978) describes a four-county effort in rural West Virginia, which took into account the special cultural and economic characteristics of the population to be served (i.e., individualism, isolation, religiosity, conservatism, distrust of newcomers, and economic deprivation). This project found individual- and family-based interventions more effective than traditional group approaches. The project also established strong linkages to ministerial associations.

Substance abuse prevention programming can be a special challenge in rural areas. Edwards and colleagues (1988) provided a good overview of several special considerations. As in most areas involving professional resource deployment, the staff members working in rural prevention activities have been trained in urban settings, so it is important to provide these professionals with orientation to the rural environment. Sarvela and McClendon (1987) reported the results of a comprehensive drug education program for sixth and seventh grade students in rural northern Michigan and northeastern Wisconsin.

Substance abuse is often hidden in rural areas, or at least not openly discussed, and even social drinking can be an unwelcome topic for disclosure due to the value orientation of the community. As a result of this denial, support for prevention activities may be lacking. Privacy, or the lack of privacy, is a major barrier to prevention programming, as well as to service delivery. The value orientation of the rural community population may not be congruent with those of the rural professionals. As a result, special attention must be given to "value-focus" prevention strategies. Finally, the often vast geographical distances that separate rural residents, along with low population density, make prevention and service delivery difficult.

Coordination among substance abuse, mental health, and primary health care service delivery is often poor in rural areas. Shortages of professional resources, inadequate distribution of services, and orientation into distinct service provider agencies limit the cooperation and collaboration between providers of care. The National Advisory Committee on Rural Health (1991) recommended to the Secretary of the Department of Health and

Human Services that alcohol, drug abuse, and mental health services be integrated with other primary care services in rural communities.

Much more research and evaluation is needed in this area, especially in identifying the optimal organizational and treatment aspects of rural substance abuse service delivery.

ALTERNATIVE SERVICE MODELS AND TREATMENT SETTINGS

Several models of alternative treatment and intervention for mental disorder have been shown to be effective for rural populations. Timpson (1983) described a project that effectively used indigenous residents in a remote Native American community to provide basic mental health services. The natural helpers were identified, trained by non-indigenous professionals, and provided ongoing training, supervision, and consultation.

Hollister and colleagues (1985) described similar efforts using natural helpers in rural North Carolina, through the Alternative Care Network Project. The project developed a series of workbooks entitled "Learning Experiences for People with Problems," which provided detailed processes and activities for helpers to use when working with persons with specific problems.[2]

Many of the innovative efforts reviewed used common ingredients: indigenous paraprofessionals and interagency collaboration. The trend for community mental health centers to be tied to fee-for-service delivery and staffing patterns is certainly a barrier to such innovation, because such fee-for-service care must be provided by professionally qualified staff.

Recent direct funding of rural mental health and substance abuse programming, through section 1440 programs under the Rural Crisis Recovery Act in the 1987 farm bill and the Rural Health Outreach Grant Program of the Federal Office of Rural Health Policy, has allowed for limited development of innovative alternatives without the pressures of the fee-for-service requirements.

Murray and Keller (1986) provide a good selection of articles describing alternative service models in their book "Innovations in Rural Community Mental Health." These articles cover a range of models, from linking mental health with primary health care settings to rural geriatric outreach.

CRISIS INTERVENTION AND EMERGENCY MENTAL HEALTH SERVICES

As discussed earlier, rural hospitals are less likely to formally provide psychiatric emergency services. As a result, the rural community mental health system is a major source for emergency mental health services and crisis intervention. The primary source for crisis intervention services, however, is the rural physician (Manolis 1987). Bassuk and colleagues (1984) noted that although the provision of mental health emergency services has assumed a central role in the delivery of community mental health services, the training of emergency workers has not kept pace. They described a project implemented in Vermont to train those people actually involved in routinely providing emergency care. The project targeted emergency medical technicians, law enforcement staff, emergency room staff, and community mental health center staff. The project attempted to ensure that the curriculum was specific to the local service delivery reality. A key factor in the project's success was the establishment of effective relationships between the participants and their organizations. The literature does not include many details on emergency mental health services in rural settings. It would seem that this area calls for further study.

PREVENTION

Although prevention is under attack in some quarters—the Alliance for the Mentally Ill (AMI) referred to prevention as "worrisome flakiness" (Torrey et al. 1990)—many innovative rural prevention efforts have been documented. Graham and Hill (1983) described the use of a toy lending library for at-risk populations. Their project, on remote Manitoulin Asland in Ontario, linked parents and children to child development paraprofessionals through the toy lending library. The project enriched the children's play environment, enhanced the social support of the families, allowed for identification of children at risk for developmental difficulties, and gave parents access to parenting education in a nonthreatening environment.

Bullis (1987) described a project that identified at-risk youth in the Dulce, NM Apache community. The project linked those youth with activities that enriched their personal perceptions of self-competence, social interaction skills, and problemsolving abilities. A significant reduction in risk factors (e.g., school failure, truancy, crime) was noted among the participants postintervention. Also in a Native American community, Tyler and colleagues (1982) developed a project designed to reduce the prevalence of emotional disorders through the support of

indigenous agencies and natural helpers by community psychology consultation.

Stress: Country Style (Cecil 1988) was a creative response to the Nation's farming crisis. This Illinois project connected outreach mental health professionals to the farming communities in crisis, and to individual farmers and farm families. The project's proactive outreach efforts bridged the gap between those in crisis and their resistance to seeking help.

Farie and Cower (1986) described how they adapted the highly successful Primary Mental Health Project (PMHP), a program for early detection and prevention of school adjustment problems, to serve a rural population. The PMHP is structured to emphasis the following:

- Focus on primary grade children.
- Active, systematic screening for those at risk.
- Use of paraprofessional helpers.
- Using school mental health professionals as consultants and trainers for aides and teachers.

THE HEALTH AND MENTAL HEALTH LINKAGE

The primary care physician is actively involved in mental health care, providing nearly 60 percent of mental health care in the United States (U.S. Congress 1988). Yet a pattern for collaboration and cooperation between the primary health care and the mental health care sectors remains the exception rather than the rule. The review of literature for this chapter revealed very limited examination of this linkage.

Burns and colleagues (1983), in evaluating linkage programs in both urban and rural areas, found general agreement that the linkage efforts were successful. Specifically relating to rural areas, the researchers found that the direct provision of mental health and consultation services was a more effective mechanism of linkage then referrals to the mental health center. The investigators also underscored the importance of shared funding between the health and mental health centers, certain special characteristics of the linkage worker, and concern with transportation and space as factors in a successful experience. Surprisingly, no negative consequences were reported.

Two examples of successful rural linkage experiences were reported by Celenze (1988), Celenze and Fenton (1981), and Prindaville and colleagues (1983). These innovative and successful programs for the broader provision of mental health services in rural areas were, however, casualties of the general fiscal retrenchment in the human services in the early 1980s.

Several examples of successful networking, including the deployment of mental health professionals to the primary care setting, were shown to be effective (Boydston 1986; Delpizzo 1988; Flaskerud and Kviz 1982). Common advantages of this linkage were noted.

- Integration with the primary health care setting enhanced the real and perceived level of confidentiality.
- Integration leads to enhanced referrals and earlier identification of persons with mental health problems.
- Integration provides for interaction between professionals reducing the sense of professional isolation.
- Integration can reduce operational costs because some overhead expenses can be shared.

SERVICES TO SPECIAL POPULATIONS: AN OVERVIEW OF CLINICAL ISSUES

Severely Mentally Ill. As noted previously, there has been a dramatic reduction of the use of institutional-based services for persons with mental illness in the past three decades. Models of services to this population have tended to be urban in design, however, and not specifically suited for the needs and resources of rural settings (Bachrach 1982).

Baker and Intagliata (1984) reviewed case management and other community support services provided to persons with severe mental illness in rural and urban settings. They found that the range of community support services offered to rural and urban residents was about the same. The clients served, however, were dissimilar. Rural persons with serious mental illness tended to be older, female, and more likely than their urban counterparts to reside in inadequate housing.

While the literature relating to persons with severe mental illness is filled with innovative urban programs, such as Fairweather lodges, consumer-

run drop-in centers and clubhouse, assertive community treatment teams, supported employment, and psychoeducational interventions to aid both recipients and families, the authors were not able to locate articles or studies of these innovations in rural communities.

Homeless Persons With Mental Illness. The review of literature found few articles relating to the issue of the delivery of services to homeless rural persons with mental illness. Sommers (1989) found rural persons with chronic mental illness had higher utilization rates for all program-based residential alternatives than their urban counterparts, while Baker and Intagliata (1984) found rural persons with chronic mental illness more likely to be living in inadequate housing than urban people with chronic mental illness.

Patton (1987) noted that homelessness in rural America has received little media or research attention. The scanty data available tend to support the notion that homelessness is a growing problem for rural areas. Homelessness among persons with mental illness is certainly an issue in rural America; but it seems that the combination of small populations and their wide dispersion results in lack of research. The special needs of rural persons who are homeless and also mentally ill or chemically dependent is a subject warranting further research and development of programs to help them.

Developmental Disabilities. Significant progress has been made in the last 30 years in the provision of services for persons with developmental disabilities. The term "developmental disability" is applied to persons who have a severe, chronic disorder (present prior to age 22) caused by mental retardation, cerebral palsy, epilepsy, or autism (Department of Health, Education, and Welfare 1971). For many of the same reasons outlined elsewhere—lack of professional resources, equipment, and facilities—rural America does not offer the person with developmental disabilities the best opportunity for meaningful community-based living and growth (Brantley and West 1980). As with persons with chronic mental illness, considerable attention has been given in the literature to urban innovations—from supported employment to community residential living and day programming. But the literature on the rural applications of such innovations is limited.

Cotten and Spirrison (1988) discussed the difficulty in providing services to older adults with developmental disabilities in rural Mississippi. They stressed the need for collaboration, outreach, and cooperation among service providers to ensure the provision of services. Menolascino and Poller (1989) noted that the life spans of persons with mental retardation

have increased five-fold in recent decades. They also concluded that persons with developmental disabilities are far better being cared for within their nuclear families and in their home communities than in more restrictive settings. Some States, such as Michigan, have been innovative in the establishment of programs that support families choosing to provide family-based community living for a family member with a developmental disability.

Children and Adolescents. The mental health needs of rural children continue to be met through a patchwork of programs and agencies. Studies have frequently noted serious problems due to poor integration of services, lack of children's mental health professionals, limited access to services, and inadequate fiscal resources directed toward child and adolescent mental health (Petti and Leviton 1986). As the authors have said before, the reality of today's rural life is far from the idyllic myth so often portrayed in the media. Murray (1991) noted that the potential for rural youth to become mentally ill is equal to or in excess of their urban peers. But the research of Achenback and colleagues (1991) and Zahner and colleagues (in press), reviewed elsewhere (Wagenfeld et al. 1994), has raised questions about Murray's conclusion. Nonetheless, many at-risk populations of rural youth are unaware of the existing mental health resources available to them (Miller et al. 1982), and as a result, cannot gain access to the service planned to serve them.

The scenario of a school counselor treating a school-related behavior problem, a community mental health center involved in outpatient counseling, a court worker dealing with abuse issues, and a social service worker managing family-related issues, all with little collaboration or integration, is the rule, not the exception in the rural United States (Mohatt and Sharer-Mohatt 1990). Several programs to ensure integration have been initiated, such as NIMH's Child and Adolescent Service System Program (CASSP), but few data on rural applications (e.g., Lubrecht 1991) are currently available.

Other Special Populations. Like services for children and adolescents, services specifically intended for women, minorities, migrants, older adults, and other special populations are often not available in the rural United States (Bergland 1988). In organizing a rural minority issues research panel for the National Association for Rural Mental Health's 1991 annual conference, Murray (personal communication, April 1991) found limited numbers of researchers actively working on rural minority topics.

Women have experienced major role changes in rural America as the need for off-farm income has led many to assume employment away from the farm (Heffernan and Heffernan 1986). Similar role changes have been noted in rural mining, oil producing, and timber communities. Such role changes have had dramatic implications for families and communities across rural America, yet little programming or research attention has been directed toward this group.

Older adults are making up an increasing portion of the general population. In rural communities, however, older adults make up a disproportionate percentage of the overall population (Murray 1991). The unique aspects of rural America may affect older residents more acutely. Inadequate public transportation, limited mental health benefits, conservative value orientation, and perceived stigma can all combine to the disadvantage of rural elderly.

The Omnibus Budget Reconciliation Act of 1987 initiated a nursing home reform effort, which mandated the screening of existing and new nursing home admissions for mental illness and developmental disabilities. The law required both alternative placement and active treatment for those with significant impairment. The impact of this requirement on rural areas is not yet known.

CHALLENGES TO RURAL MENTAL HEALTH SERVICE DELIVERY FINANCING

The severe economic problems of the Nation are acknowledged by most individuals and were a major theme in the 1992 presidential election. As the economy is severely shaken from trade imbalances, savings and loan failures, auto industry plant closings, farm failures, and a national debt of unimaginable size, it is not hard to understand how rural mental health care financing can be overshadowed.

The cost of health care is consuming an ever increasing portion of the United States' gross national product (GNP). Today, approximately 12 percent of the GNP is spent on health care, more than that spent by any other industrialized nation. The cost of mental health services is included in this trend. While the debate on health care reform continues, Federal budget policy has diverted increasing amounts of revenue away from mental health services. Bergland (1988) reported that the amount of Federal revenues directed toward mental health services declined by nearly one-third from 1980 to 1987.

Escalating health care costs are spurring movement toward managed care systems in both health and mental health care (Goldman and Frank 1991). Rural America, where mental health and health have already been rationed for decades due to poor accessibility and lack of human and fiscal resources, will require special attention in implementing any managed care system.

Medicaid is a major source of public financing for services to persons with mental illness and developmental disabilities. The Medicaid system operates on a "medical model" of specialized care, which is much more adaptable to the urban environment (Mohatt 1992). Rural providers, facing chronic shortages of mental health professionals, experience great difficulty meeting the standards of the Medicaid mental health clinic service provider. For example, to be reimbursed under Medicaid, all care delivered must be ordered by a physician. As a result, although there is a shortage of physicians in rural areas, valuable physician time is used to authorize mental health providers to perform mental health procedures.

Additionally, Medicaid does not favor the use of mid-level mental health practitioners. In its review of rural mental health and substance abuse issues, the National Advisory Committee on Rural Health (1991) noted that access to care in many rural areas has been enhanced or made possible by using primary care mid-level providers (e.g., nurse practitioners, physician assistants, and nurse-midwives). The same is true in the area of rural mental health, with master's-prepared professions (psychologies, counselors, and social workers) providing many mental health services, the committee added. The advisory committee called for increased study and policy discussion in this area.

CONSUMER MOVEMENT

While groups such as the Association for Retarded Citizens (ARC), the Alliance for the Mentally Ill (AMI), the Mental Health Association (MHA), and many others have begun to play a much more significant role in advocacy across the mental health system, these groups have shown little interest in the rural environment. Consumer involvement is discussed frequently in the literature, yet its rural component is addressed only in a limited way.

SUMMARY

The mental health funding cuts and the block grant shift of the last decade have placed an increased emphasis on fee-generating services. In already underserved rural areas, this has generated immense challenges for mental health professionals on how to provide services to persons other than those with chronic mental illness. This chapter has discussed alternatives and innovations that have proven successful. Linkages with primary care physicians and indigenous residents who have been trained to provide basic mental health services under the supervision of mental health professionals are just two of the ways in which mental health professionals have risen to meet the challenges placed before them.

A review of the literature produced few articles about rural programs addressing the issues of substance abuse, services to women, children, the elderly, those with severe mental illness or developmental disability, and the homeless, or crisis intervention programs. Much work needs to be done to provide adequate services to these special rural populations. It is hoped that the renewed interest in rural areas generated by the farm crisis will produce additional programs addressing the needs of these often underserved populations.

NOTES

1. Several colleagues, in commenting on this situation, have spoken of a "fugitive literature." Some older NIDA publications (Department of Health, Education, and Welfare 1977, 1978*a*, 1978*b*) provide program descriptions. Readers with a particular interest in this area might want to contact any of the following for addition information: Office of Substance Abuse Prevention Clearinghouse, P.O. Box 2345, Rockville, MD 20847-2345, (800) 729-6686; National Association of State Alcohol and Drug Abuse Directors, 444 North Capitol Street, NW, Washington, DC 10001, (202) 783-6868; or National Rural Institute of Alcohol and Drug Abuse, c/o Arts and Sciences Outreach, University of Wisconsin, Eau Claire, WI 54702-4004, (715) 836-2031.

2. At the time of writing, these workbooks were still available from Dr. William Hollister, Department of Psychiatry, University of North Carolina, Chapel Hill, NC.

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AUTHORS

Morton O. Wagenfeld, Ph.D.
Professor of Sociology and Community Health Services
Western Michigan University

J. Dennis Murray, Ph.D.
Professor of Psychology
Mansfield University

Dennis F. Mohatt
Director
Menominee County Community Mental Health Center
and
President
National Association for Rural Mental Health

Jeanne C. DeBruyn
Research Associate
Department of Sociology
Western Michigan University

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